OCT 4 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26268

1. PLACE OF DEATH

County: Stone — Registration District No.: 843 — File No.: 129

Township: Washington — Primary Registration District No.: 4513 — Registered No.: 61

City: Galena (No. ..... St. ..... Ward)

2. FULL NAME Elara B. Wilcox

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Female	White	Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. E. Wilcox

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE			
54 Years	7 Months	26 Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Osteopath

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Milan
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Dr Hannibal Fox

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chelsea
(STATE OR COUNTRY) Vermont

12. MAIDEN NAME OF MOTHER Henrietta Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Nashville
(STATE OR COUNTRY) Ohio

14. INFORMANT .....
(Address) .....

15. FILED Sept 19 27 — J. W. Davis, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1927

17. I HEREBY CERTIFY, That I attended deceased from 1924, 19..., to Aug 31, 1927, that I last saw him alive on Aug 30, 1927, and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endocarditis
90 D

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? yes

DID AN OPERATION PRECEDE DEATH? No — DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) [illegible], M. D.
, 19 (Address) Galena Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Galena Cemetery	Sept 1 1927
20. UNDERTAKER	**ADDRESS**
Ernest Hilton	Crane Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... .....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19—

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT: (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF
20. UNDERTAKER	ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH

County Stone — Registration District No. 843 — File No. 129

Township Washington — Primary Registration District No. 45-13 — Registered No. 61

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Clara B. Wilcox

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Div

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Jan 5th 1873

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	7	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

NAME OF FATHER

BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

INFORMANT Francis B. Wilcox
(Address)

15. FILED Septe 1927 T. W. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1927

17. I HEREBY CERTIFY: That I attended deceased from ....., 19.... to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cronic Endocarditis

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? yes
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. H. Young, M. D
, 19 (Address) Galena Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Galena Cemetery — DATE OF BURIAL: Sept 11 1927

20. UNDERTAKER: Ernest Hilton — ADDRESS: Crane Mo.

SUPPLEMENTARY

N. B.—Ev... ...nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE O... ...terms, so that it may be properly c...sified. Exact statement of OCCUPATION is very ...portant.

S-26268